A CONTRIBUTION TO JACKSONIAN EPILEPSY AND THE SITUATION OF THE LEG CENTRE.—Dr. William Osler, of the University of Pennsylvania, records, in the January issue of *The American Journal of the Medical Sciences*, the history of an instructive case of Jacksonian epilepsy. His case lasted over fourteen years, the convulsions beginning in the left hand, at first monobrachial, then extending to the leg, afterwards becoming unilateral, and finally general; at first without loss of consciousness. For the last nine years of the illness there were remarkable intermissions, lasting for six or seven months, once an entire year. Six months after the onset the left leg got weak and stiff. For four years, the tenth, eleventh, twelfth, and thirteenth of the illness, the seizures were frequent. During this period there were six weeks of unconsciousness in which the spasms were very frequent, fifty to eighty in the day. Ten months prior to the final attacks there was freedom from convulsions. The intellectual faculties were unimpaired. The case is unusual in the limitation of the lesion to the ascending frontal convolution, and to its fasciculus of white matter, scarcely involving the gray substance, which is commonly affected in cortical epilepsy. The accurate localization, and the remarkable absence of tissue-changes in the immediate vicinity, give the case the nature of an exact physiological experiment. With this limited lesion of the motor area, there was permanent paralysis with contracture of one extremity and epileptiform convulsions. Another feature of interest in the case is the light it throws on the situation of the leg centre. The fibrous mass was situated entirely within the anterior part of the paracentral lobule, limited in extent, confined chiefly to the medullary fibres of the superior frontal fasciculus, and only touched the gray matter in places. A point to be referred to is the absence of the paralysis of the leg for the first six years, for, if the convulsions and monoplegia were caused by the same lesion, how explain the late onset of the latter? From the fibroid state of the tumor it might reasonably be inferred that it was originally larger and had shrunk, but the absence of puckering on the surface, and the way in which the margins merged with the contiguous parts, make it probable that the growth was always small—so small, in fact, that at one period of its development, it may have caused sufficient irritation to induce the convulsions, and yet at the same time not involve the special fasciculi of white fibres to the extent of producing weakness of the leg or monoplegia.

A CASE OF LODGMENT OF A BREECH-PIN IN THE BRAIN; RECOVERY.—Dr. G. W. H. Kemper, of Muncie, Indiana, reports in the January number of *The American Journal of the Medical Sciences*, a very instructive case in which a lad received a compound fracture of the frontal bone, immediately above the right frontal sinus, by a bursting gun. The breech-pin was found imbedded in the brain at a distance of one-half inch, and was withdrawn by the aid

of dressing-forceps. No untoward symptoms were developed until the evening of the fourth day, when a convulsion ensued because of pent-up pus, and after the removal of the cause no further trouble followed. The lesson to be derived from the study of the case is the necessity of maintaining free drainage, thus preventing an abscess from extending in the brain and becoming fatal.

SYPHILIS OF THE NERVOUS SYSTEM.—Dr. S. G. Webber read before the Boston Society for Medical Improvement, an abstract of a paper which is to appear in the coming volume of the Boston City Hospital Report. The following are some of the conclusions that he has reached: There is no pathognomonic symptom of syphilis of the nervous system; the diagnosis must be made by grouping the manifestations, and viewing them and their history as a whole. Among the more frequent peculiarities is irregularity of the phenomena and their ephemeral nature, disappearing to come again. Headache is the most common and the earliest symptom of the central nervous system, and gives timely warning that the subsequent dangers may be avoided. Its characteristics are severity, with remissions or intermissions. The pain is persistent, or returns again and again. It is often, but by no means always, most severe in the latter part of the day or night. It may be limited or general, unilateral or bilateral. Nausea and dizziness are generally absent. The ocular nerves are more frequently paralyzed than the other cranial nerves, and in general, paralysis is preceded by headache or trifacial neuralgia. Hemiplegia is less likely to be sudden than to occur gradually, to be intermittent, to be preceded by headache, and to be accompanied by numbness of the same parts. Syphilis of the spinal cord is less common than cerebral syphilis. Its prognosis is much less favorable, and it also has no pathognomonic symptom. Perhaps many of the cases of locomotor ataxia reported cured were really cases of syphilitic neuritis. Syphilitic neuritis of peripheral nerves is not common, and is not easily recognized as such. The time at which nervous symptoms appear after the primary sores varies in Dr. Webber's cases from two and a half months to twenty-five years; the majority coming, as is reported by other observers, within three years. The reader hesitated to say much of prognosis. If headache exists alone, or if the symptoms are variable and intermittent, the prospect is fair. If there be organic change, recovery is doubtful, although the disease may be arrested. Some cases must be treated, at least intermittently, for many years, even after symptoms have disappeared. Slight cases may be treated with fifteen or twenty grains of iodide of potassium three times daily, continued many weeks after apparent recovery. In serious cases temporizing is dangerous, and iodide of potassium and mercury should be given in sufficient doses. Of the iodide, from seventy to two hundred and twenty-five grains have been given in the cases reported. Larger doses have been given by the